

## Immunization History Form/Waiver

**\*Please allow 72 Business hours to be processed. Check your Gulflink account to verify your immunization status\***

Name: Last	First	Phone (   )
University ID Number 8 1	Date of Birth / /	Age

	Vaccination	Month/Day/Year	Month/Day/Year	Month/Day/Year
STATE REQUIRED	<b>MMR</b> 1 <sup>st</sup> vaccine must be given after 12 months of age; must be in 1971 or later; 2 <sup>nd</sup> dose must be at least 28 days after 1 <sup>st</sup> dose	/ /	/ /	*Two MMR vaccines may be substituted with a positive Rubella/Mumps/Rubeola titer (must submit laboratory results indicating immunity)
	<b>HEPATITIS B</b> Series of 3 vaccinations * OR sign waiver below	/ /	/ /	/ /
	<b>MENINGOCOCCAL/MCV4</b> OR sign waiver below	/ /	Booster Needed if 1 <sup>st</sup> dose given before age 16	/ /

	Vaccination	Month/Day/Year	Month/Day/Year	Month/Day/Year
RECOMMENDED NOT MANDATORY	Hepatitis A	/ /	/ /	
	Hepatitis A & B Combined	/ /	/ /	/ /
	Human Papillomavirus (HPV)	/ /	/ /	/ /
	PPD/TB	/ / Date Placed	/ / Date Read	Result: _____ mm induration Positive ( ) Negative ( )
	Tetanus Diphtheria Please indicate which tetanus vaccine was given	/ / TD	/ / Tdap	/ / Tdap
	Varicella Series of 2 vaccinations	/ /	/ /	Incidence of Disease Date:
	Serogroup B Meningococcal (2 dose)	/ /	/ /	

**\*An official stamp from a doctor's office, clinic, or health department AND an authorized signature must appear below or this form WILL NOT be accepted\***

Official office stamp

\_\_\_\_\_  
Physician or Authorized Signature

\_\_\_\_\_  
Date

WAIVER OPT-OUT	<p style="text-align: center;">If you have <b>not</b> completed the Hepatitis B series or received the Meningitis vaccine, please <u>check</u> the corresponding boxes below. <b><u>Waivers DO NOT REQUIRE physician's signature</u></b></p> <p><input type="checkbox"/> I have read the information regarding Hepatitis B. I am aware of the potential fatal nature of the disease and choose not to be vaccinated.</p> <p><input type="checkbox"/> I have read the information regarding Meningococcal Meningitis. I am aware of the potential fatal nature of the disease and choose not to be vaccinated.</p> <p style="text-align: center;">_____ Signature of Student (or parent/guardian if under 18)</p> <p style="text-align: center;">_____ Date</p>
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